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Effective	Upon Approval	Applicability	Detroit Wayne Integrated Health Network
Last Revised	N/A		
Next Review	1 year after approval		

Practice Guideline for Recurrent Hospitalization and Recidivism

POLICY

It is the policy of Detroit Wayne Integrated Health Network (DWIHN) to establish guidelines that can help its provider network and is based on evidence-base literature in the area.

PURPOSE

The psychiatric readmission rate or recidivism is high, and this is particularly true for individuals having severe mental illness especially in adult population. State expectation for 30-day readmission rate has been less than 15%. Historically, DWIHN has not been able to meet that standard for adult population most of the quarters. Several good and best clinical practices can be considered to decrease psychiatric hospitalizations and readmissions rates.

APPLICATION

1. The following groups are required to implement and adhere to this policy:
    a. DWIHN Board,
    b. DWIHN Staff including the following
        1. DWIHN PIHP Staff
        2. DWIHN Community Care Clinic Staff (Direct Care Staff)
        3. DWIHN Community Care Clinic Staff (DWIHN staff operating as a CCBHC)
        4. DWIHN Crisis Care Center Staff
        5. DWIHN Mobile Crisis Staff
    c. Contractual Staff

d. Clinically Responsible Service Provider (CRSP) and their subcontractors
e. Specialty Providers
f. Crisis Services Vendors
g. Designated Collaborating Organizations (DCO)

2. This policy serves the following populations:
    a. Adults
    b. Children
    c. Individuals with Intellectual and/or Developmental Disabilities (I/DD)
    d. Serious Mental Illness (SMI),
    e. Serious Emotional Disturbance (SED),
    f. Substance Use Disorder (SUD)
    g. Autism
    h. Mild/Moderate levels of care
3. This policy impacts the following contracts/service lines:
    a. Autism
    b. Certified Behavioral Health Clinics
    c. General Fund
    d. Grants
    e. MI-HEALTH LINK
    f. Medicaid
    g. SUD

KEYWORDS

1. Hospitalization
2. Recidivism
3. Readmission

STANDARDS

The following guidelines can be helpful in decreasing recidivism rate. The evidence is based on external literature or internal data. These guidelines are intended to be used as guidance and should not replace your own review (particularly for updates), clinical judgment and medical necessity standards.

General Guidelines (All Populations)

1. Comprehensive Assessment and Risk Stratification

a. Utilize standardized tools to assess psychiatric symptoms, functioning, and risk of rehospitalization (e.g., LOCUS, CALOCUS, PHQ, MICHICANs, C-SSRS).

b. Identify key risk factors: medication non-adherence, poor social supports, co-occurring substance use, recent hospitalization, homelessness, trauma history.

2. Individualized Crisis and Safety Planning

a. Co-develop and regularly update crisis/safety plans with the person served and their support system.
b. Share crisis plans with local EDs, crisis response teams, and inpatient units with consent.
c. Ensure that person served leaves with a safety plan after a crisis episode that list number of DWIHN Crisis call line (888-IN-CRISIS).
d. If the person-served refuses and/or declines to complete and/or sign the Crisis Plan and/or Safety Plan, staff should complete it based on their knowledge and assessment of the person including but not limited to their risk and protective factors as well as availability of supports. Continue to revisit and re-attempt completion of member participation/signature using motivational interviewing techniques every visit or at least every 60 days or within 14 days of a crisis whichever is sooner.

3. Discharge Planning and Transitional Care

a. Hospitals to complete risk assessments, discharge planning meetings, coordination of care with outpatient providers, accurate medication reconciliation and assure that each person leaves with a discharge appointment and safety plan.
b. CRSP to initiate discharge planning on admission to psychiatric inpatient care by outreaching the person-served while they are in the hospital. Attempt face-to-face visit for engagement at hospital if agency has hospital liaisons and case managers.
c. Provide a face-to-face or telehealth follow-up appointment within 7 days post-discharge (preferably within 48-72 hours).
d. Ensure warm handoffs between inpatient and outpatient teams.
e. For persons at risk of recidivism, Treatment teams to increase number of contacts in the weeks following hospitalization to avoid risk of readmission.
f. Individualized Plan of Service (IPOS) should be updated to include additional goals and interventions focused on decreasing recurrent hospitalization and recidivism.
g. Please see VI. Figures and Attachments
    1. Care Pathway for Recidivistic Hospitalized Adult (Figure 2)
    2. Care Pathway for Recidivistic Hospitalized Youth (Figure 3)

4. Assertive Community-Based Care

a. Utilize Assertive Community Treatment (ACT) for individuals with recurrent admissions and recidivism when meeting medical necessity.
b. Intensive Crisis Stabilization Services (ICSS), or similar intensive services for individuals at high risk.
c. Ensure regular community-based contact for high-need individuals.
d. Seek additional guidance and consultation from Outcomes Improvement Committee as necessary.

5. Medication Management and Adherence

a. Refer members who are non-adherent with taking their own medication to (Med Drop) Services to ensure medication delivery and compliance.

b. Prioritize long acting injectables (LAIs) for individuals with repeated non-adherence.

c. Provide psycho-education and shared decision-making about medications.

6. Peer Support and Recovery-Oriented Services

a. Integrate Certified Peer Support Specialists (PSS) and Recovery coaches into care teams.

b. Promote person-centered, recovery-based approaches to enhance hope and empowerment.

7. Social Determinants and Care Coordination

a. Screen for housing, food insecurity, transportation, and employment barriers.

b. Coordinate care across behavioral health, physical health, and social services.

8. Data-Driven Quality Monitoring

a. Use EHR, Performance Indicators and other State data (e.g., BH-TEDS, PCE, HEDIS) to track recidivism.

    1. See attached Performance Indicator Module Guide to see steps on accessing the data

b. Monitor 30-day and 90-day readmission rates and conduct root cause analyses and improvement plans submitted by CRSP's.

Adult-Specific Guidelines

1. Use Alternate Crisis Continuum of Care Services

a. Consider Crisis Stabilization Units (CSU) and Crisis Residential Units (CRU) for facility-based alternates.

b. Use Partial Hospitalization Program and/or Intensive Crisis Stabilization Services (ICSS) for persons who meet inpatient criteria but could be safely discharged to outpatient level of care with support from such high intensity programs.

c. Safety planning with Crisis call number should be provided to all persons.

    1. This is particularly important for preadmission screening units and teams. PAR teams and units should review previous crisis encounters, requests for services, psychiatric admissions and make all efforts to prevent psychiatric readmission and recidivism using least restrictive safe disposition

    2. PAR teams and Units are expected to review Crisis alerts and take input from the outpatient providers. This is particularly important for members who are recidivistic and end up in emergency departments and crisis units recurrently.

    3. If the person-served has been seen by psychiatrist, PAR clinicians are expected to review the psychiatrist note and incorporate their opinion into their decision making. If PAR clinician's decision and disposition is different from the psychiatry consultant's recommendation, it should be explained in the PAR note.

2. ***Use of ACT or Intensive Case Management (ICM)***

a. Adults with severe mental illness (SMI) and multiple hospitalizations should be considered for ACT

or ICM.

b. Ensure team-based care includes psychiatry, nursing, peer support, and case management.

3. ***Trauma-Informed Care***

a. Screen for trauma using validated tools (e.g., ACEs, PTSD Checklist).

b. Integrate trauma-informed practices across all service settings.

4. ***Co-Occurring Disorders Integration***

a. Implement integrated dual diagnosis treatment (IDDT) for individuals with SMI and substance use disorders.

b. Co-locate SUD and MH treatment when feasible.

5. Forensic and Justice-Involved Adults

a. Partner with jails, courts, and probation officers to ensure continuity of behavioral health services.

b. Utilize jail diversion and reentry programs**.**

c. Ensure combined court orders are followed after discharge from inpatient hospitals and second and continuation ordered are renewed.

d. Ensure that Assisted Outpatient Treatment (AOT) is requested by filing petition with court as clinically indicated on person-served who are non-compliant and at risk of hospitalization or rehospitalization because of treatment non-compliance.

6. Psychosocial Rehabilitation

a. Participation in Clubhouse has shown to decrease risk of hospitalization, recurrent hospitalizations and recidivism.

b. Ensure person-served who can benefit from the clubhouse program are proactively referred to clubhouses. Participation for more than 3 days per week has shown greater association with decreasing recidivism, therefore, encouraging engagement is an important goal as well.

7. Evidence Based Practices:

a. *Use evidence-based interventions for general population as well as for specific target populations*

1. **Assertive Community Treatment (ACT)**
Why: Provides comprehensive, team-based, 24/7 community support to prevent crisis and promote long-term stability.
Target: Adults with SMI and frequent psychiatric hospitalizations or homelessness.
Citation: Bond et al. (2001). *Dis Manag Health Outcomes*, 9(3), 141–159. https://doi.org/10.2165/00115677-200109030-00003

2. **Peer Support Services**
Why: Lived experience fosters engagement, hope, and connection, reducing isolation post-discharge.
Target: Adults with SMI, especially those with trauma histories or limited trust in traditional systems.
Citation: Chinman et al. (2014). *Psychiatr Serv*, 65(4), 429–441. https://doi.org/10.1176/appi.ps.201300244

3. **Post-Discharge Follow-Up Within 7 Days**

Why: Timely follow-up reduces risk of relapse, suicide, and disengagement from care.
Target: All psychiatric inpatients, especially high-risk discharges (e.g., suicidal ideation).
Citation: Olfson et al. (2002). *Arch Gen Psychiatry*, 59(1), 49–56. https://doi.org/10.1001/archpsyc.59.1.49

4. **Medication Adherence Support & Long-Acting Injectables (LAIs)**
   Why: Improves consistency of treatment in individuals with poor medication compliance, reducing symptom exacerbation.
   Target: Adults with schizophrenia, bipolar disorder, or treatment-resistant illness.
   Citation: Marcus & Zummo (2014). *Schizophr Res*, 159(1), 109–115. https://doi.org/10.1016/j.schres.2014.07.031
5. **Integrated Dual Diagnosis Treatment (IDDT)**
   Why: Concurrent treatment for SMI and substance use disorder (SUD) reduces hospitalization and improves recovery outcomes.
   Target: Adults with co-occurring mental illness and substance use disorders.
   Citation: Drake et al. (2004). *Psychiatr Rehabil J*, 27(4), 360–374. https://doi.org/10.2975/27.2004.360.374
6. **Housing First & Supportive Housing**
   Why: Housing stability is essential for engagement in treatment and long-term recovery.
   Target: Homeless individuals or those in unstable housing with SMI.
   Citation: Tsemberis et al. (2004). *Am J Public Health*, 94(4), 651–656. https://doi.org/10.2105/AJPH.94.4.651
7. **Psychoeducation for Patients and Families**
   Why: Increases understanding of symptoms, early warning signs, and coping strategies, which lowers relapse rates.
   Target: Adults with schizophrenia, bipolar disorder, or chronic depression, and their support systems.
   Citation: Pitschel-Walz et al. (2001). *Schizophr Bull*, 27(1), 73–92. https://doi.org/10.1093/oxfordjournals.schbul.a006861
8. **Care Coordination and Case Management**
   Why: Facilitates integrated care and communication across settings, reducing care fragmentation.
   Target: High-need adults with complex psychosocial and medical comorbidities.
   Citation: Burns et al. (2002). *Br J Psychiatry*, 180(3), 216–221. https://doi.org/10.1192/bjp.180.3.216
9. **Psychosocial Rehabilitation via Clubhouses**
   Why: Clubhouses provide structured, voluntary environments that foster social inclusion, skill-building, and meaningful activity—reducing hospitalization through empowerment.
   Target: Adults with serious mental illness who benefit from long-term social, vocational, and community support.
   Citation:
   Faheem, S., Lyons, M., Moody, M., et al. (2025). Impact of Clubhouses in Reducing Psychiatric Readmission Risk. *Cureus*, 17(3): e80559. https://doi.org/10.7759/cureus.80559
10. **Critical Time Intervention (CTI)**
    Why: Supports individuals during critical transitions (e.g., discharge) to maintain housing, treatment, and stability.
    Target: Adults with serious mental illness (SMI), especially those experiencing

homelessness or system disconnection.
Citation: Susser et al. (1997). *Am J Public Health*, 87(2), 256–262. https://doi.org/10.2105/AJPH.87.2.256

11. **Transitional Discharge Model (TDM)**
Why: Promotes continuity of therapeutic relationships and support immediately after hospital discharge.
Target: Adults leaving inpatient psychiatric care who lack post-discharge support.
Citation: Forchuk et al. (2007). *Arch Psychiatr Nurs*, 21(2), 80–86. https://doi.org/10.1016/j.apnu.2006.10.006

Children and Youth-Specific Guidelines

1. Family-Driven and Youth-Guided Care

a. Engage family or guardians in all phases of planning and treatment.
b. Use ICCW/wraparound services for youth with complex needs.

2. School and Community Integration

a. Coordinate with schools for behavioral intervention plans (BIPs), IEPs, and school reintegration support.
b. Use School-Based Mental Health Services when appropriate.

3. Early Identification and Trauma-Focused Interventions

a. Screen for Adverse Childhood Experiences (ACEs) and trauma.
b. Implement Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for youth with trauma.

4. Mobile Crisis and In-Home Stabilization

a. Use mobile crisis response, intensive crisis stabilization services and intensive services (e.g., Home-Based Services).
b. Avoid hospitalization by addressing crises in the least restrictive setting, CRU, CSUs.

5. Evidence-Based Practices:

a. ***Use evidence-based practices that can decrease the recidivism rates for children with the evidence in their areas***

1. **Multisystemic Therapy (MST)**
What: Home- and community-based intervention for youth with severe emotional and behavioral problems.
Why it works: Targets family, peer, school, and neighborhood influences.
Evidence: Significantly reduces psychiatric hospitalization rates and length of stay. Youth receiving MST are 2–4 times less likely to be re-hospitalized within 6 months.
Best for: Youth with conduct disorder, mood disorders, or multiple prior admissions.
Citation: Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic Therapy for Antisocial Behavior in Children and Adolescents* (2nd ed.). Guilford Press.

2. **Family-Based Crisis Intervention (FBCI)**
What: Single-session, evidence-based model delivered in emergency departments (ED)

for suicidal youth and their families.
Why it works: Combines elements of motivational interviewing, cognitive behavioral therapy (CBT), and family therapy.
Evidence: Reduced psychiatric admissions by 35–40% after ED visits for suicidal ideation.
Best for: Adolescents in acute crisis or suicidal distress.
Citation: Wharff, E. A., Ginnis, K. M., & Ross, A. M. (2012). Family-based crisis intervention with suicidal adolescents in the emergency room: A pilot study. *Social Work*, 57(2), 133–143. https://doi.org/10.1093/sw/sws017

3. **Partial Hospitalization and Intensive Outpatient Programs (PHP/IOP)**
What: Step-down levels of care providing daily therapy while the youth lives at home.
Why it works: Prevents inpatient admission and reduces need for readmission.
Evidence: Studies show decreased re-hospitalization compared to standard outpatient follow-up. High engagement rates with family therapy components correlate with lower relapse risk.
Citation: Walter, H. J., Vernacchio, L., Trudell, E. K., Bromberg, J. R., Young, J., & Tullius, K. (2020). Short-term outcomes for adolescents discharged from psychiatric hospitalization. *Psychiatric Services*, 71(8), 788–794. https://doi.org/10.1176/appi.ps.201900446
4. **Dialectical Behavior Therapy for Adolescents (DBT-A)**
What: Adapted DBT model for teens with suicidal or self-harming behaviors.
Why it works: Teaches emotion regulation, distress tolerance, interpersonal effectiveness.
Evidence: Reduces suicide attempts, emergency visits, and psychiatric admissions. Especially effective for adolescents with borderline traits or complex trauma.
Citation: Mehlum, L., Tørmoen, A. J., Ramberg, M., Haga, E., Diep, L. M., Stanley, B. H., ... & Grøholt, B. (2014). Dialectical behavior therapy for adolescents with repeated suicidal and self-harming behavior: A randomized trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, 53(10), 1082–1091.e2. https://doi.org/10.1016/j.jaac.2014.07.003
5. **Intensive Care Coordination with Wraparound (ICCW)/Wraparound Services**
What: Individualized care planning model that coordinates behavioral health, educational, and social services.
Why it works: Promotes system collaboration and family engagement.
Evidence: Youth in ICCW/wraparound services show lower rates of hospitalization and better functional outcomes. Reduces inpatient use by up to 50% in high-risk populations.
Citation: Bruns, E. J., & Suter, J. C. (2010). Summary of the wraparound evidence base. *National Wraparound Initiative*.
6. **Transition or Aftercare Services (e.g., SAFETY Program, CTI-Youth)**
What: Structured post-discharge support programs focusing on continuity of care, safety planning, and skill-building.
Why it works: Bridges the gap between hospital discharge and outpatient care.
Evidence: SAFETY (for suicidal teens) includes safety planning + CBT = fewer repeat crisis episodes. CTI-Youth (Critical Time Intervention) reduces psychiatric readmission rates significantly over 9 months.
SAFETY Program Citation: Asarnow, J. R., Berk, M. S., Hughes, J. L., & Anderson, N. L. (2015). The SAFETY Program: A treatment-development trial of a cognitive-behavioral family treatment for adolescent suicide attempters. *Journal of Clinical Child & Adolescent*

Psychology, 44(1), 194–203. https://doi.org/10.1080/15374416.2013.850697
CTI-Youth Citation: Susser, E., Valencia, E., Conover, S., Felix, A., Tsai, W. Y., & Wyatt, R. J. (1997). Preventing recurrent homelessness among mentally ill men: A "critical time" intervention after discharge from a shelter. *American Journal of Public Health*, 87(2), 256–262.

7. **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**
What: An evidence-based treatment for youth with PTSD and related symptoms.
Why it works: Trauma is a common underlying driver of repeated crises and hospital use.
Evidence: Youth receiving TF-CBT after discharge are less likely to be re-hospitalized than those without targeted trauma treatment.
Citation: Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2016). *Trauma-Focused CBT for Children and Adolescents: Treatment Applications*. Guilford Press.

8. **School-Based Mental Health Services**
What: Embedded services in educational settings including counseling, behavior support, and crisis intervention.
Why it works: Prevents escalation of symptoms by increasing access and early response.
Evidence: Access to school-based services has been associated with fewer hospital admissions and improved engagement in care post-discharge.
Citation: Atkins, M. S., Hoagwood, K. E., Kutash, K., & Seidman, E. (2010). Toward the integration of education and mental health in schools. *Administration and Policy in Mental Health and Mental Health Services Research*, 37(1–2), 40–47. https://doi.org/10.1007/s10488-010-0299-7

Specific Populations and Diagnostic Considerations

1. ***Individuals with Serious and Persistent Mental Illness (SPMI)***
    a. Prioritize evidence-based interventions such as ACT, Cognitive Behavioral Therapy for Psychosis (CBTp), and Supported Employment (IPS).
    b. Address anosognosia with motivational interviewing and shared decision-making.
    c. Consider referral to First Episode Psychosis (FEP) program (NAVIGATE) where applicable.

2. ***Individuals with Intellectual/Developmental Disabilities (IDD)***
    a. Provide dual diagnosis services tailored for IDD and behavioral health.
    b. Use Positive Behavioral Supports (PBS) and Functional Behavior Assessments (FBA).

3. ***Individuals with Co-occurring Substance Use Disorders***
    a. Use integrated treatment models like Seeking Safety, DBT-SUD, IDDT or MI/CBT combinations.
    b. Include Medication-Assisted Treatment (MAT) when appropriate (e.g., Suboxone, Vivitrol).

4. ***Transition-Aged Youth (16–26)***
    a. Implement specialized Transition-Aged Youth (TAY) programs.
    b. Support independent living skills, education, and employment. Consider goals that

address these.

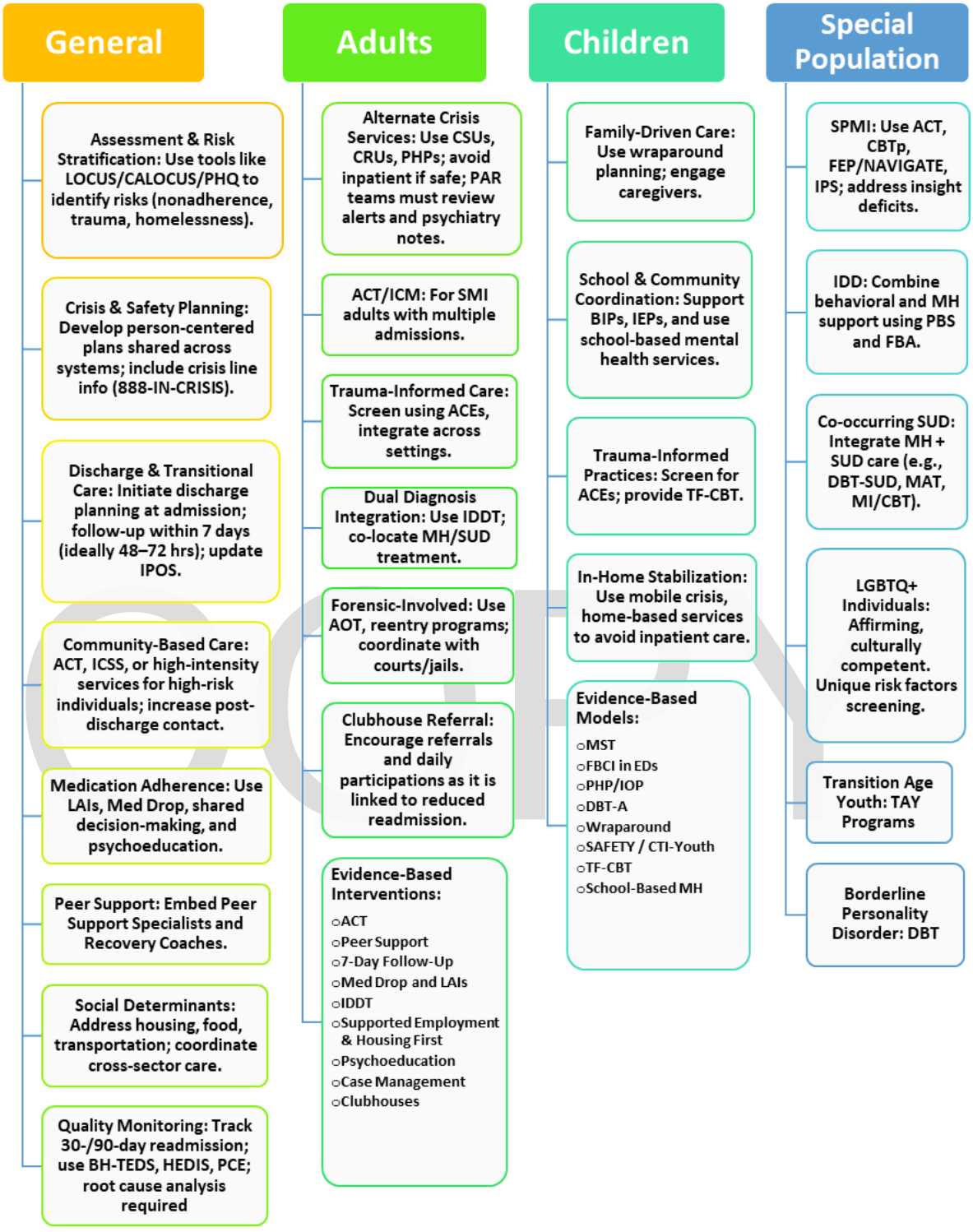
5. ***LGBTQ+ Individuals***
    a. Use affirming, culturally competent care and screen for unique risk factors including stigma, bullying, and family rejection.
    b. Offer linkage to LGBTQ+ peer and community supports.
6. ***Borderline Personality Disorder***
    a. Dialectical behavior therapy (DBT) should be used where medically appropriate to decrease the risk of harm and psychiatric admission.
    b. DBT is a comprehensive, evidence-based treatment for borderline personality disorder (BPD), but there have been promising findings for patients with BPD and substance use disorders (SUDs), persons who meet criteria for binge-eating disorder, and depressed elderly patients. It has found to decrease risk of suicide attempts, psychiatric hospitalization, medical risk of parasuicidal behavior, angry behavior, and emergency room visits.

Implementation Recommendations

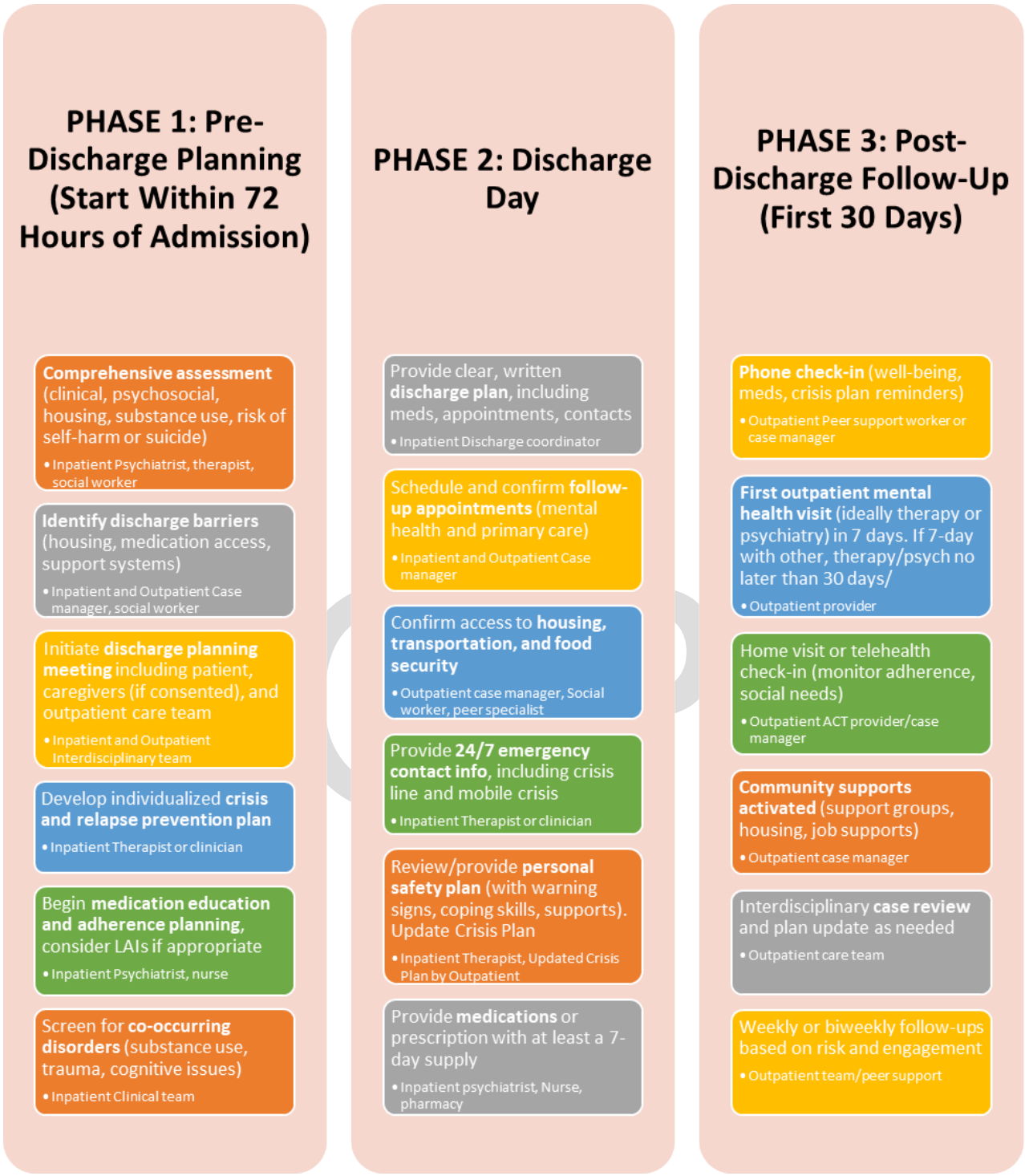
1. Training: Ensure all providers are trained in trauma-informed care, motivational interviewing, suicide prevention (e.g., ASIST), and recovery principles.
2. Cultural Competence: Provide culturally and linguistically appropriate services (CLAS) to meet diverse community needs.
3. Evaluation: Quarterly Performance Indicators, HEDIS Measures, Compliance reviews, annually review outcomes and update protocols based on findings and new evidence.

Figures and Attachments

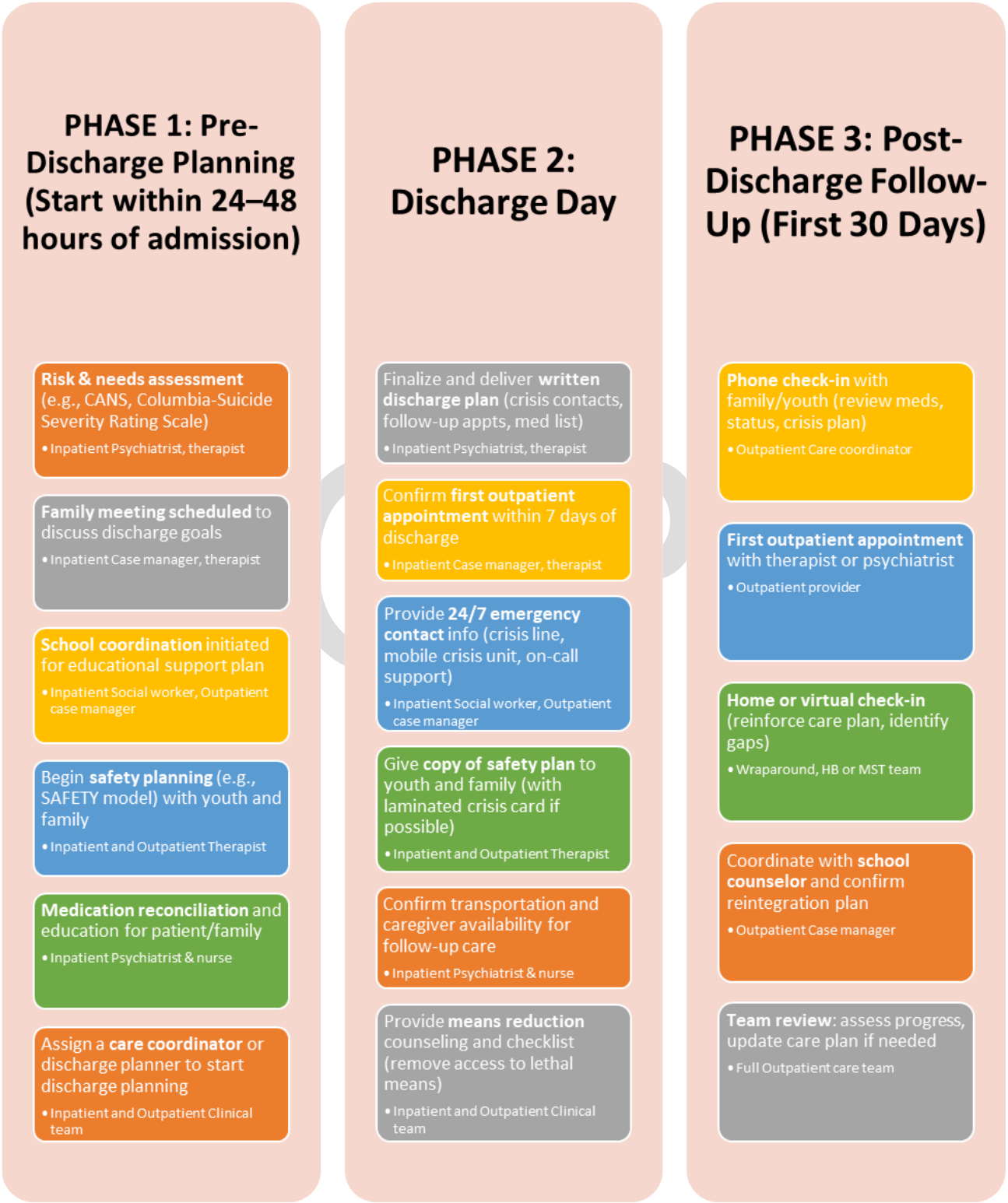
Summary of Key Guidelines (Figure 1)



Discharge Care Pathway for Recidivistic Hospitalized Adult (Figure 2)


PHASE 1: Pre-Discharge Planning (Start Within 72 Hours of Admission)
Comprehensive assessment (clinical, psychosocial, housing, substance use, risk of self-harm or suicide)
• Inpatient Psychiatrist, therapist, social worker
Identify discharge barriers (housing, medication access, support systems)
• Inpatient and Outpatient Case manager, social worker
Initiate discharge planning meeting including patient, caregivers (if consented), and outpatient care team
• Inpatient and Outpatient Interdisciplinary team
Develop individualized crisis and relapse prevention plan
• Inpatient Therapist or clinician
Begin medication education and adherence planning, consider LAIs if appropriate
• Inpatient Psychiatrist, nurse
Screen for co-occurring disorders (substance use, trauma, cognitive issues)
• Inpatient Clinical team
PHASE 2: Discharge Day
Provide clear, written discharge plan, including meds, appointments, contacts
• Inpatient Discharge coordinator
Schedule and confirm follow-up appointments (mental health and primary care)
• Inpatient and Outpatient Case manager
Confirm access to housing, transportation, and food security
• Outpatient case manager, Social worker, peer specialist
Provide 24/7 emergency contact info, including crisis line and mobile crisis
• Inpatient Therapist or clinician
Review/provide personal safety plan (with warning signs, coping skills, supports). Update Crisis Plan
• Inpatient Therapist, Updated Crisis Plan by Outpatient
Provide medications or prescription with at least a 7-day supply
• Inpatient psychiatrist, Nurse, pharmacy
PHASE 3: Post-Discharge Follow-Up (First 30 Days)
Phone check-in (well-being, meds, crisis plan reminders)
• Outpatient Peer support worker or case manager
First outpatient mental health visit (ideally therapy or psychiatry) in 7 days. If 7-day with other, therapy/psych no later than 30 days/
• Outpatient provider
Home visit or telehealth check-in (monitor adherence, social needs)
• Outpatient ACT provider/case manager
Community supports activated (support groups, housing, job supports)
• Outpatient case manager
Interdisciplinary case review and plan update as needed
• Outpatient care team
Weekly or biweekly follow-ups based on risk and engagement
• Outpatient team/peer support

Discharge Care Pathway for Recidivistic Hospitalized Youth (Figure 3)



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    a. *SAMHSA's National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit*. (2020). https://www.samhsa.gov
    b. *Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) KIT*. https://store.samhsa.gov/product/integrated-treatment-co-occurring-disorders-evidence-based-practices-ebp-kit/SMA08-4367
2. **Centers for Medicare & Medicaid Services (CMS)**.
    a. *Reducing Avoidable Hospitalizations Among Nursing Facility Residents* https://www.cms.gov
3. **National Council for Mental Wellbeing**
    a. *Behavioral Health Crisis Services: A Component of the Continuum of Care*. (2021) https://www.thenationalcouncil.org
4. **National Institute of Mental Health (NIMH)**.
    a. *Research on Hospital Readmissions in Mental Health*. https://www.nimh.nih.gov

Michigan-Specific Resources

1. **Michigan Department of Health and Human Services (MDHHS)**
    a. *Behavioral Health and Developmental Disabilities Administration (BHDDA) Practice Guidelines* https://www.michigan.gov/mdhhs
2. **Michigan's PIHP and CMHSP System**
    a. Annual performance indicators, BH-TEDS data reporting manuals, and care integration documents (available through internal portals or by request from MDHHS-BHDDA).

Evidence-Based Practice Literature

1. Burns, T., & Santos, A. B. (1995). Assertive community treatment: An update of randomized trials. *Psychiatric Services*, 46(7), 669-675. https://doi.org/10.1176/ps.46.7.669
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3. Dixon, L. B., et al. (2010). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophrenia Bulletin*, 36(1), 48-70.
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5. Borum, R., Bartel, P., & Forth, A. (2006). *Structured Assessment of Violence Risk in Youth (SAVRY)*.

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6. Bruns, E. J., Walker, J. S., Zabel, M., et al. (2010). Intervening in the lives of youth with complex behavioral health challenges and their families: The role of the wraparound process. *American Journal of Community Psychology*, 46(3-4), 314–331.
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Special Populations

1. Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. Guilford Press. [For DBT]
2. Najafi's, L. M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. Guilford Press.
3. American Academy of Child and Adolescent Psychiatry (AACAP). (2009). *Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior*. https://www.aacap.org
4. Centers for Disease Control and Prevention (CDC). *Adverse Childhood Experiences (ACEs) Study*. https://www.cdc.gov/violenceprevention/aces/index.html
5. Chapman A. L. (2006). Dialectical behavior therapy: current indications and unique elements. *Psychiatry (Edgmont (Pa. : Township))*, *3*(9), 62–68.

QUALITY ASSURANCE/IMPROVEMENT

DWIHN shall review and monitor providers adherence to this policy as outlined in the Quality Assurance Performance Improvement Plan (QAPIP) Work-plan.

Oversight and monitoring will be conducted through the review of reports and analysis by the Quality Improvement Team and provider self-monitoring through desk audit reviews.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff, Direct Contracted Network Providers, and their subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended..

LEGAL AUTHORITY

1. Michigan Department of Health and Human Services Medicaid Provider Manual (in effect, and as as amended)
2. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program (PIHP/CMHSP contracts in effect, and as amended)

RELATED POLICIES AND PROCEDURES

1. Michigan Mission Based Performance Indicator (MMBPI) Reporting Requirements

2. Psychiatric Inpatient Hospitalization
3. Voluntary and Involuntary Mental Health Treatment and AOT Policy

CLINICAL POLICY

YES

INTERNAL/EXTERNAL POLICY

EXTERNAL/INTERNAL

Attachments

PerformanceIndicatorModuleGuide.pdf

Approval Signatures

Step Description	Approver	Date
Compliance/Administrative Review	Rai Williams: Director of Contract Management	Pending
Compliance/Administrative Review	Yolanda Turner: Vice President Of Legal Affairs	Pending
Compliance/Administrative Review	Sheree Jackson: Vice President Of Compliance	10/2025
Compliance/Administrative Review	Brooke Blackwell: Vice President Of Governmental Affairs	10/2025
Compliance/Administrative Review	Manny Singla: Deputy Chief Executive Officer	10/2025
Compliance/Administrative Review	Stacie Durant: Vice President Of Finance	10/2025
Clinical Review Committee	Marlena Hampton: Director of Utilization Management	10/2025
Clinical Review Committee	Stacey Sharp: Associate Vice President of Clinical Operatio	08/2025
Clinical Review Committee	Cassandra Phipps: Director of Childrens Initiatives	07/2025
Clinical Review Committee	Jacquelyn Davis: Associate Vice President - Access and Strateg	07/2025

Clinical Review Committee	Ryan Morgan: Director of Residential Services	07/2025
Clinical Review Committee	Matthew Yascolt: Interim Director of Substance Use Disorder	07/2025
Clinical Review Committee	Daniel West: Director of Crisis Services	07/2025
Clinical Review Committee	Shama Faheem: Chief Medical Officer	07/2025
Clinical Review Committee	Polly McCalister: Director of Recipient Rights	07/2025
Clinical Review Committee	Vicky Politowski: Director of Integrated Care	07/2025
Clinical Review Committee	April Siebert: Director of Quality Improvement	07/2025
Clinical Review Committee	Marianne Lyons: Director of Adult Initiatives	07/2025
Clinical Review Committee	Melissa Moody: Vice President Of Clinical Operations	07/2025
NCQA Committee	Margaret Keyes-Howard: Customer Service Engagement Manager	07/2025
NCQA Committee	Tania Greason: Quality Administrator	07/2025
NCQA Committee	Allison Smith: Director of Strategic Operations	07/2025
NCQA Committee	Justin Zeller: Project Manager [AS]	07/2025
Unit Approval	Shama Faheem: Chief Medical Officer	07/2025

Applicability

Detroit Wayne Integrated Health Network

Standards

No standards are associated with this document